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STAFF DATA ON H.R. 1:

MEDICARE-MEDICAID

MEDICAID ALTERNATIVES

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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CONTENTS

Medicaid Alternatives:

Part A. Possible Modification of Present Medicaid Program:

	Page
Introduction	1
Present Medicaid Program	1
Problems With Present Medicaid Program	2
Possible Modifications of Present Medicaid Program	3
A. General Consideration	3
B. Eligibility and Financing	3
C. Benefits	3
D. Administration	4
E. Relationship to Other Federal Health Programs	4
F. Revenue Sharing Aspects	5

Tables, Part A:

Medicaid Costs by Federal and State Share, Fiscal years, 1973–1975	5
1. Summary Table: Impact of Medicaid Alternatives on Federal and State Costs, Fiscal Year 1973	6
2. Medicaid and ICF Medical Vendor Expenditures for Categorically Needy and Medically Needy, Basic and Optional Services, Fiscal Year 1973	8
3. Medical Vendor Payments by Type of Service, Title XIX and ICF's, Fiscal Year 1973	10
4. Total Medical Vendor Payments (Title XIX and ICF's) by Categorically Needy and Medically Needy Status, Fiscal Year 1973	13
5. Medicaid Recipients by Categorically Needy and Medically Needy Status, Fiscal Year 1973	15
Part B:	
Table 1	21

Part B. Medicaid Issues Raised by Committee Welfare Actions:

Introduction	17
Newly Eligible Aged, Blind, and Disabled Recipients	18
Employment Participants and the "Notch Problem"	19
State Responsibility for Premium Payments in States Which Supplement Income Above $2,400 for Families	22
Summary of Costs of Medicaid Proposals	22

MEDICAID ALTERNATIVES

A. POSSIBLE MODIFICATION OF PRESENT MEDICAID PROGRAM

Introduction

The staff has developed for Committee discussion purposes an approach toward basic changes in the Medicaid program. It involves:

1. Federal assumption of State and local Medicaid expenditures for provision of the 6 mandatory Medicaid services plus intermediate care to those persons eligible for cash welfare assistance.
2. A uniform benefits structure throughout the country for the mandatory services and intermediate care.
3. Payment of benefits for the six mandatory services and intermediate care by the Bureau of Health Insurance (Medicare administrative agency) in behalf of Medicaid recipients certified by States as eligible for such coverage.
4. Continuation of State responsibility for determination of eligibility and survey and inspection of health care facilities.
5. Regular Federal, State, and local matching toward the costs of all coverage for the medically-indigent and costs of optional services for the indigent and State responsibility for administration, determination of eligibility, and benefit payments for all optional services.

The medically-indigent would be eligible for benefits subject to premium payments as previously approved by the Committee.

Present Medicaid Program

Medicaid is the current State-Federal program with responsibility for financing medical care for the indigent (cash assistance eligibles) and the medically indigent—persons who meet all the requirements for cash assistance eligibility in the State except that their income is too high. Today, eligibility for Medicaid is determined by each State just as each State sets its own cash assistance level. While States must cover all cash assistance eligibles, they do not have to cover the medically indigent category, but may do so at their option. The upper income limit of eligibility for the medical indigent cannot exceed 133⅓ percent of the AFDC cash payment level in a State.

Benefits under Medicaid vary from State to State, both as to the items covered and the scope or duration of benefits. Each State however, must include in its program six basic services:

1. Inpatient hospital care.
2. Outpatient hospital care.
3. Other laboratory and X-ray services.
4. Physicians services.

5. Skilled nursing home care.
6. Home health services.

States have the option of covering additional services such as intermediate care, dental services and drugs. States are also free to determine the number of days of care, the number of doctors' visits, etc. which may be covered under the State plan.

Medicaid is administered by State governments following general Federal guidelines. At the State level, the program is usually administered by the State welfare department with certain professional functions subcontracted to the State health department. At the Federal level the program is administered by the Medical Services Administration (MSA) within HEW. MSA is responsible for issuing guidelines, providing assistance to the States and monitoring State performance.

Medicaid is financed with Federal funds matched by State and local funds. States' matching percentages vary according to per capita income in a State, with Federal matching ranging from 50 percent to 83 percent of costs. Federal financing is funded through general revenues. Total Medicaid costs for fiscal 1973 are estimated at approximately $9 billion of which some $5 billion represents Federal matching. State and local costs, now at $4 billion a year, constitute a heavy and increasing financial burden.

Problems With Current Medicaid Program

There are a number of problems associated with the Medicaid program. H.R. 1 contains a number of scattered provisions which deal with some of these, but the bill in general does not address the major problems. Among the major problems are the following:

Burden on State Finances

Medicaid (including intermediate care) currently costs State and local governments about $4 billion a year. Thus, at a time when the States are seeking fiscal relief through revenue sharing Medicaid accounts for a sizeable and increasing proportion of their expenditures. H.R. 1 contains a number of Medicaid cost control provisions, but cost estimates under the bill still show the States with projected yearly costs of well over $3.6 billion.

Unequal Benefits from State to State

Although States are required to offer certain benefits (inpatient and outpatient hospital care, nursing home care, home health services, physicians' services and laboratory and X-ray services), there is a variation among the States in the scope of these benefits. For example, States set various limits on the number of hospital or nursing home days, resulting in an uneven basic benefit structure throughout the country.

Uneven Administration

Medicaid is administered by 50 separate jurisdictions (48 states—Puerto Rico and the District of Columbia) apart from local political subdivisions. This results in duplication, and often uneven application of regulations and standards.

Provider Dissatisfaction

The State Medicaid programs often have unrealistic or sharply varying levels of payment for practitioners and providers. Additionally, the programs also involve a significant amount of "red-tape" from the practitioners' viewpoint.

Discussion of Possible Modification of Present Medicaid

A. GENERAL CONSIDERATIONS

State and local financing problems, uneven benefit structures and duplicate administration could be substantially alleviated, and major revenue-sharing achieved, through greater Federal responsibility for the Medicaid program. This could involve full Federal funding for the six basic Medicaid services (plus intermediate care) for the categorically indigent, rather than the current State-Federal sharing of the costs of these services, and continuing State-Federal sharing for the costs of covering the medically-indigent and optional services. The effect of this approach would be to relieve States of some $2.4 billion in Medicaid expenditures in fiscal 1973.

Certain administrative functions which parallel those carried out by the Bureau of Health Insurance for Medicare (such as payments to hospitals and physicians) could be assumed by the Bureau of Health Insurance thereby eliminating varying methods and rates of payment, duplicative activity and reducing paperwork.

Additionally a national minimum benefit structure could be established for the six basic services and intermediate care to assure equity in coverage of services to the indigent throughout the 50 States.

B. ELIGIBILITY AND FINANCING

All cash assistance eligibles would have the costs of providing the six mandatory services and intermediate care assumed by the Federal Government. This would bring into Medicaid, the States of Arizona and Alaska which have been unable to participate heretofore. Coverage in these two States would involve an additional Federal expenditure estimated at $15–$20 million annually.

State and local governments would continue to match the costs of providing optional services to the indigent and all services to the medically-indigent.

Eligibility for enrollment would be certified for 6-month periods and could be revoked only in case of fraud or non-payment of premium (where applicable).

False certification of eligibility by a State would be ground for requiring full State payment of costs with respect to those falsely certified.

The States would collect appropriate premiums on behalf of any medically-indigent person eligible for benefits under the Medicaid program.

Federal participation would be financed through general revenues.

C. BENEFITS

Benefits provided would be the six mandatory Medicaid benefits—covering medically-necessary: inpatient hospital care (60 days); outpatient hospital care; physicians' services; skilled nursing home

care; home health services; and laboratory and X-ray services—plus intermediate care.

Under this approach the additional costs due to the proposed uniform benefit level are estimated at $450 million (of which about one-half involves bringing Medicaid physician reimbursement to the Medicare level.)

The States, subject to the regular Medicaid matching formula, would be at liberty to continue to provide or to add optional benefits such as drugs and dental care.

A nominal co-payment charge could be required of the medically indigent on patient-initiated *elective* services such as outpatient visits to a physician's office, or a clinic visit or house calls. For example, the patient could be required to pay $2 per visit for the first 2 visits in any month. No deductible or coinsurance would be required of cash assistance eligibles.

D. ADMINISTRATION

States would continue to be responsible for certifying eligibility and maintaining eligibility records. The State would also administer any optional benefits such as drugs or dental services, which they choose to continue or to add. Additionally, the States would continue to perform provider survey and inspection functions under contract with the Secretary as they do in Medicare.

The proposal contemplates transferring a number of other administrative functions such as payment to providers and practitioners and utilization review which parallel those performed by the Bureau of Health Insurance of Medicare, from the State to the Federal level.

At the Federal level, the Bureau of Health Insurance would assume responsibility for administering the 6 basic services and intermediate care. With the exception of intermediate care, these services parallel those which BHI currently administers under Medicare. With respect to payments to providers, carriers and intermediaries would continue to be used as at present under Medicare. If a State so chose, as under existing law, it could serve as the fiscal agent.

The Medical Services Administration within HEW, which currently administers Medicaid at the Federal level, would be terminated. (Any minor continuing Federal responsibilities could be assumed by the Social Security Administration.)

The program would consolidate all of Medicare's and Medicaid's review mechanisms, and statutory quality standards and would consolidate Federal administrative responsibilities and activities with respect to peer review and health care standards within a single unit in the Bureau of Health Insurance.

Payments to practitioners and providers would be made in accordance with Medicare procedures. A uniform claims and payment procedure would be established. Institutions would be paid "reasonable costs", based upon audited costs data. Practitioners would be paid "reasonable charges" utilizing Medicare procedures where they accept such payments as payment in full for all Medicaid eligibles.

E. RELATIONSHIP TO OTHER FEDERAL HEALTH PROGRAMS

The Medicare program would continue for those 65 or over (and the disabled as proposed in H.R. 1). The Medicaid fund would "buy-

in" to Part B of Medicare for those indigent persons eligible for Medicare (as State Medicaid programs currently do). Medicaid would also pay the Medicare co-payments and deductibles for those persons (to the extent and where applicable).

F. REVENUE SHARING ASPECTS

States, and in some cases localities, are projected to spend, including administrative costs, a total of $4 billion as their Medicaid share in fiscal 1973. Of that amount, between 75 percent and 80 percent is for services to the indigent.

The extent of the State savings under the suggestion outlined in this pamphlet would vary, depending upon the size of the eligible population, the value of the State's current Medicaid package, the State matching percentage and the States' cash assistance and medical-indigence standards.

In summary, all States would receive substantial savings under this alternative.

In those States where local Governments made a substantial contribution towards Medicaid and other Federally-assisted welfare costs a proportionate share of savings could be required to pass through to the local governments.

The following table indicates under the alternative, the magnitude of the aggregate increase in estimated Federal Medicaid costs and the magnitude of the decrease in State-local Medicaid costs for each of fiscal years 1973 through 1975.

MEDICAID COSTS BY FEDERAL AND STATE SHARE, FISCAL YEARS, 1973-1975

[Millions of dollars]

	Current law	Revised Medicaid	Fiscal impact
Fiscal 1973:			
Total costs	*8,802*	*9,252*	*+450*
Federal share	4,859	7,588	+2,729
State and local share	3,943	1,664	−2,279
Fiscal 1974:			
Total costs	*10,271*	*10,797*	*+526*
Federal share	5,649	8,868	+3,219
State and local share	4,622	1,929	−2,693
Fiscal 1975:			
Total costs	*11,987*	*12,601*	*+614*
Federal share	6,593	10,366	+3,773
State and local share	5,394	2,235	−3,159

74-705—72——2

TABLE 1

SUMMARY TABLE: IMPACT OF MEDICAID ALTERNATIVE [1] ON FEDERAL AND STATE COSTS, FISCAL YEAR 1973

[Millions of dollars]

	Current law		Revised Medicaid		Net savings to States under revised Medicaid
	Federal share	State share	Federal share	State share	
Alabama	119	33	142	9	24
Alaska					
Arizona					
Arkansas	34	9	42	1	8
California	720	720	1,208	232	488
Colorado	46	33	74	6	27
Connecticut	58	58	81	36	22
Delaware	6	6	12	1	5
District of Columbia	27	27	40	14	13
Florida	85	54	122	19	35
Georgia	124	55	171	8	47
Guam					
Hawaii	17	17	27	6	11
Idaho	14	5	18	1	4
Illinois	256	256	410	92	164
Indiana	66	53	[1] 110	10	43
Iowa	17	12	24	5	7
Kansas	40	27	58	9	18
Kentucky	66	24	77	12	12
Louisiana	63	22	81	4	18
Maine	29	12	40	1	11
Maryland	66	66	89	43	23
Massachusetts	208	208	280	136	72
Michigan	195	195	304	85	110
Minnesota	102	78	149	33	45
Mississippi	48	10	55	3	7
Missouri	37	25	54	8	17
Montana	10	5	14	1	4
Nebraska	33	24	47	10	14
Nevada	7	7	13	1	6

See footnotes at end of table, p. 7.

TABLE 1—Continued

SUMMARY TABLE: IMPACT OF MEDICAID ALTERNATIVE[1] ON FEDERAL AND STATE COSTS, FISCAL YEAR 1973—Continued

[Millions of dollars]

	Current law		Revised Medicaid		Net savings to States under revised Medicaid
	Federal share	State share	Federal share	State share	
New Hampshire	7	5	10	2	3
New Jersey	118	118	201	32	86
New Mexico	22	8	28	2	6
New York	874	874	1,296	454	420
North Carolina	81	30	95	16	14
North Dakota	11	5	15	1	[2] 4
Ohio	144	124	243	25	99
Oklahoma	69	31	91	10	21
Oregon	21	15	33	3	12
Pennslyvania	223	179	317	85	94
Puerto Rico	18	52	[2] 48	[2] 22	[2] 30
Rhode Island	27	27	40	14	13
South Carolina	46	13	56	2	11
South Dakota	12	6	18	....	6
Tennessee	73	25	91	7	18
Texas	293	141	412	22	119
Utah	22	9	28	3	6
Vermont	16	8	22	3	5
Virgin Islands	1	1	[2] .5	[2] .5	[2] .5
Virginia	108	60	135	33	27
Washington	64	63	108	19	44
West Virginia	26	8	32	2	6
Wisconsin	107	83	159	31	52
Wyoming	3	2	5	....	2
U.S. total	4,859	3,942	7,212	1,590	2,352

[1] 100 percent Federal funding of basic services (includes ICF's) for categorically needy; current matching rate on all other expenditures.

[2] Would be subject to dollar ceiling.

TABLE 2

MEDICAID AND ICF MEDICAL VENDOR EXPENDITURES FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, BASIC AND OPTIONAL SERVICES, FISCAL YEAR 1973

[Millions of dollars]

	Estimated total expenditures, title XIX and ICF, current law	Estimated Federal share of expenditures, title XIX and ICF, current law	Estimated State share of expenditures, title XIX and ICF, current law	Estimated expenditures for basic Medicaid services and ICF for categorically needy, current law	Estimated expenditures for optional services for categorically needy and services for medically needy
Alabama	151	119	33	108	43
Alaska					
Arizona					
Arkansas	43	34	9	37	6
California	1,441	720	720	976	464
Colorado	80	46	33	66	14
Connecticut	116	58	58	45	72
Delaware	13	6	6	11	2
District of Columbia	54	27	27	26	28
Florida	139	85	54	97	42
Georgia	179	124	55	151	28
Guam					
Hawaii	33	17	17	21	12
Idaho	19	14	5	17	2
Illinois	512	256	256	317	195
Indiana	120	66	53	98	22
Iowa	29	17	12	16	13
Kansas	67	40	27	45	22
Kentucky	90	66	24	43	46
Louisiana	85	63	22	70	15
Maine	41	29	12	38	3
Maryland	132	66	66	46	86
Massachusetts	416	208	208	144	272
Michigan	390	195	195	218	171
Minnestoa	181	102	78	105	77
Mississippi	58	48	10	38	20
Missouri	62	37	25	42	20
Montana	15	10	5	12	3

See footnotes at end of table, p. 9.

TABLE 2

MEDICAID AND ICF MEDICAL VENDOR EXPENDITURES FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, BASIC AND OPTIONAL SERVICES, FISCAL YEAR 1973—Continued

[Millions of dollars]

	Estimated total expenditures, title XIX and ICF, current law	Estimated Federal share of expenditures, title XIX and ICF, current law	Estimated State share of expenditures, title XIX and ICF, current law	Estimated expenditures for basic Medicaid services and ICF for categorically needy, current law	Estimated expenditures for optional services for categorically needy and services for medically needy
Nebraska	57	33	24	33	24
Nevada	14	7	7	12	2
New Hampshire	12	7	5	8	4
New Jersey	236	118	118	168	65
New Mexico	30	22	8	23	7
New York	1,749	874	874	841	909
North Carolina	111	81	30	52	59
North Dakota	16	11	5	11	5
Ohio	268	144	124	213	55
Oklahoma	100	69	31	68	33
Oregon	36	21	15	30	6
Pennsylvania	402	223	179	211	191
Puerto Rico	70	18	52	26	44
Rhode Island	55	27	27	25	29
South Carolina	58	46	13	48	10
South Dakota	18	12	6	18	0
Tennessee	98	73	25	72	26
Texas	434	293	141	371	63
Utah	31	22	9	20	11
Vermont	24	16	8	17	8
Virgin Islands	1	1	1	0	1
Virginia	168	108	60	76	92
Washington	127	64	63	88	39
West Virginia	34	26	8	25	9
Wisconsin	190	107	83	120	70
Wyoming	5	3	2	5	0
U.S. total [1]	8,802	4,859	3,942	5,361	3,441

[1] Columns do not add to total due to rounding.

Source: Based on State estimates in OA-25, November 1971.

TABLE 3

MEDICAL VENDOR PAYMENTS BY TYPE OF SERVICE, TITLE XIX AND ICF'S, FISCAL YEAR 1973

[Millions of dollars]

	Inpatient General and TB Hospital [1]	Outpatient services [1]	Nursing home services [1]	ICF's	Physicians' services [1]	Lab and X-ray services [1]	Home health services [1]	Optional services [1]
Alabama	29	3	39	13	25	1	2	44
Alaska								
Arizona								
Arkansas	7			25	5			6
California	641	73	241	37	335	11	3	333
Colorado	16	2	28	11	12	1		15
Connecticut	32	3	60		8			17
Delaware	5	1			3			2
District of Columbia	26	5	7	5	6			7
Florida	33	5	43	3	14			43
Georgia	49	6	52	6	40		1	29
Guam								
Hawaii	11	2	15		7	1		1
Idaho	5		8		3			2
Illinois	193	12	14	156	40	1	1	104

Indiana	21	2	12	50	12	2	...	22
Iowa	8	1	1	...	8	...	...	13
Kansas	20	2	5	20	12	...	...	15
Kentucky	28	3	13	7	16	...	...	24
Louisiana	28	2	21	13	7	1	1	16
Maine	13	1	1	16	7	...	...	3
Maryland	58	11	19	17	11	...	...	40
Massachusetts	156	14	131	31	27	2	4	87
Michigan	126	9	119	34	53	7	...	50
Minnesota	31	4	40	64	15	1	1	30
Mississippi	14	1	14	...	10	...	...	20
Missouri	17	2	16	...	11	...	1	22
Montana	3	...	4	2	2	...	...	3
Nebraska	12	1	8	21	5	1	...	11
Nevada	4	...	4	1	2	...	...	2
New Hampshire	5	1	...	...	3	...	...	3
New Jersey	58	13	77	2	31	1	1	73
New Mexico	9	1	3	6	4	1	1	7
New York	745	5	584	79	107	37	13	454
North Carolina	45	5	14	...	19	...	...	32
North Dakota	3	...	6	...	2	...	...	4
Ohio	99	13	46	48	13	...	1	57
Oklahoma	27	...	52	...	14	1	...	8
Oregon	11	1	1	11	5	1	...	6
Pennsylvania	244	4	123	2	33	1	1	114

See footnotes at end of table, p. 12.

TABLE 3—Continued

MEDICAL VENDOR PAYMENTS BY TYPE OF SERVICE, TITLE XIX AND ICF'S, FISCAL YEAR 1973—Con.

[Millions of dollars]

	Inpatient General and TB Hospital [1]	Outpatient services [1]	Nursing home services [1]	ICF's	Physicians' services [1]	Lab and X-ray services [1]	Home health services [1]	Optional services [1]
Puerto Rico	37				22	4		33
Rhode Island	27	2	7	5	4			9
South Carolina	13	1	18	7	9			10
South Dakota	3		7	5	2			
Tennessee	28	5	3	23	13			27
Texas	87	9	36	176	61	9		64
Utah	9	2	6	6	3			5
Vermont	8		5	3	3			5
Virgin Islands	1	1						
Virginia	54	10	11	27	22		2	49
Washington	43	4	40	6	20	1	1	27
West Virginia	16	2			8			10
Wisconsin	33	4	78		18			63
Wyoming	1		1	3	1			
U.S. total	3,193	248	2,034	938	1,113	84	36	2,024

[1] Includes non-Federally matched payments, as well as medical vendor payments for both the categorically needy and the medically needy.

[2] Columns do not add to totals due to rounding.

Source: November 1971, OA-25, forecasts by States of their expenditures.

TABLE 4

TOTAL MEDICAL VENDOR PAYMENTS (TITLE XIX AND ICF's), BY CATEGORICALLY NEEDY AND MEDICALLY NEEDY STATUS, FISCAL YEAR 1973

[Millions of dollars]

	Total M.V.P.	Categorically needy	Medically needy
Alabama	151	151	....
Alaska	....	....	....
Arizona	....	....	....
Arkansas	43	43	....
California	1,441	1,218	222
Colorado	80	80	....
Connecticut	116	52	65
Delaware	13	13	....
District of Columbia	54	30	24
Florida	139	139	....
Georgia	179	179	....
Guam	....	....	....
Hawaii	33	22	11
Idaho	19	19	....
Illinois	512	396	116
Indiana	120	120	....
Iowa	29	29	....
Kansas	67	57	10
Kentucky	90	58	31
Louisiana	85	85	....
Maine	41	41	....
Maryland	132	62	70
Masachusetts	416	179	237
Michigan	390	249	140
Minnesota	181	126	56
Mississippi	58	58	....
Missouri	62	62	....
Montana	15	15	....
Nebraska	57	41	16
Nevada	14	14	....
New Hampshire	12	11	1
New Jersey	236	236	....
New Mexico	30	30	....
New York	1,749	1,084	666
North Carolina	111	72	39

See footnotes at end of table, p. 14.

TABLE 4—Continued

TOTAL MEDICAL VENDOR PAYMENTS (TITLE XIX AND ICF's), BY CATEGORICALLY NEEDY AND MEDICALLY NEEDY STATUS, FISCAL YEAR 1973—Continued

[Millions of dollars]

	Total M.V.P.	Categorically needy	Medically needy
North Dakota	16	15	1
Ohio	268	268	....
Oklahoma	100	74	27
Oregon	36	36	....
Pennsylvania	402	270	132
Puerto Rico	70	39	31
Rhode Island	55	30	24
South Carolina	58	58	....
South Dakota	18	18	....
Tennessee	98	98	....
Texas	434	434	....
Utah	31	24	7
Vermont	24	21	4
Virgin Islands	1	....	1
Virginia	168	106	62
Washington	127	109	18
West Virginia	34	34	....
Wisconsin	190	178	12
Wyoming	5	5	....
U.S. total [1]	8,802	6,778	2,024

[1] Columns do not add to totals due to rounding.

Source: November 1971, OA-25, forecasts by States of their expenditures.

TABLE 5

MEDICAID RECIPIENTS BY CATEGORICALLY NEEDY AND MEDICALLY NEEDY STATUS, FISCAL YEAR 1973

	Categorically needy	Medically needy	Total
All recipients	19,677,000	3,860,000	23,537,000
Age 65 or over	3,128,000	872,000	4,000,000
Blindness	127,000	10,000	137,000
Permanent and total disability	1,740,000	260,000	2,000,000
Aid to families with dependent children	13,682,000	2,718,000	16,400,000

Source: Based on National Center for Social Statistics data for recipients in the different categories in 1969, on NCSS forecasts of recipients for fiscal year 1973 and on MSA estimates of the distribution of these recipients between medically needy and categorically needy on the basis of monthly distributions in fiscal year 1970 and fiscal year 1971.

B. MEDICAID ISSUES RAISED BY COMMITTEE WELFARE ACTION

INTRODUCTION

Part A of this booklet contained a general discussion of the present Medicaid program, a list of some of the major problems with the Medicaid program and staff discussion of possible changes in the benefits, financing, and administration of the present Medicaid program. The most important of these changes would be a Federal assumption of State and local Medicaid expenditures for provision of the six mandatory Medicaid services, plus intermediate care to those persons eligible for cash welfare assistance.

This section of the booklet deals with three major questions raised with respect to Medicaid by the Committee actions on the welfare sections of H.R. 1. The issues are:

1. Newly eligible aged, blind, and disabled recipients.—The Committee amendment would add several million new recipients in the aged, blind and disabled categories. Under present law, all cash assistance recipients must be covered under Medicaid. The House bill, however, waives this requirement as it provides that any persons newly made eligible for cash assistance in a State as a result of H.R. 1 need not be covered under Medicaid. This would result in a possibly controversial inequity because one aged person in a State would be covered by Medicaid and another might not, even though both had identical assets and income.

The Committee, however, tentatively agreed, to incorporate the House provision allowing the States discretion in terms of Medicaid coverage for those aged, blind and disabled persons who become newly eligible for cash assistance under the Committee bill.

2. Workfare participants.—The Committee bill would result in about 40 percent of current AFDC recipients being transferred to the Employment Corporation. Under the present Medicaid law, except to the extent that they might qualify as medically indigent or are eligible for State supplemental payments, these people would lose their Medicaid eligibility and consequently they may be considerably worse off financially than a family which remained on AFDC. The question for Committee decision is whether Workfare participants should be eligible for Medicaid benefits and whether and the extent to which the Federal Government should finance such benefits.

3. The "Notch" problem.—Unless Medicaid coverage is to continue indefinitely, as earnings or income rises, a "notch" will occur when a person suddenly loses Medicaid benefits at whatever specific income level is chosen for the Medicaid cut off. Just below this income point, a person might not want to seek greater earnings since additional earnings could make him ineligible for Medicaid. The Committee will have to decide whether it wants to deal with this notch problem and, if so, in what fashion.

A further explanation of these three problems and possible means by which the Committee might deal with them follows.

Newly Eligible Aged, Blind, and Disabled Recipients

Present Law and House Bill

Under present law, all cash assistance recipients in a State must be covered by the Medicaid program. Under the House version of H.R. 1, any persons newly made eligible for cash assistance as a result of H.R. 1 would not have to be covered under Medicaid, unless a State so chose. This provision essentially waives the requirement that States must cover all cash assistance recipients under Medicaid.

Prior Committee Action

The Committee's earlier decisions with respect to the aged, blind and disabled provisions in H.R. 1 would result in making several million additional aged, blind and disabled persons eligible for cash assistance. The Medical Services Administration of HEW estimated that the Committee actions would result in an increase of about 75 percent in the number of aged, blind and disabled cash assistance recipients eligible for Medicaid. However, they point out that a substantial number of these new cash assistance recipients (some 400,000) are currently covered as medically-indigent in States with such programs. Adjusting for this factor, they estimate a net increase of some 60 percent in the Medicaid-eligible population in the aged, blind and disabled categories.

At an earlier session, the Committee tentatively agreed to the provision in the House bill which says that States need not cover these new welfare eligibles under the Medicaid program.

Problem

If the Committee does not cover the newly eligible cash recipients under Medicaid it could result in a controversial inequity because one aged person in a State would be covered by Medicaid and another might not, even though both had identical assets and income. For example, assume a State which presently pays an aged recipient $100 monthly. Today, an aged person with $120 of monthly income would be ineligible for welfare. However, under the Committee amendment, both individuals would be on welfare—the first would get an additional $30 added to his welfare check and the second would receive a payment of $10 to add to his other income. Both recipients would then have identical total incomes of $130 monthly but only the first would be eligible for Medicaid in many States.

Additionally, cash assistance grants are generally assumed to be structured so as to only cover basic living necessities, such as food, clothing and shelter. Cash assistance payments, today, do not usually include a factor for medical expenses.

Proposal

The staff suggests continuing the provision in present law requiring that all cash assistance recipients be covered under Medicaid. This approach deals equitably with those aged, blind, and disabled persons with equal assets and income. However premium payments would be required of all recipients with incomes (from all sources) in excess of $130 monthly in the case of an individual, and $200 monthly in the case of a family of 2 persons or more: This cost-sharing approach is discussed in greater detail in the section which follows.

Costs

Based upon current Medicaid expenditures for the aged, blind and disabled, and an estimated increase of 60 percent in Medicaid recipients in those categories, HEW has estimated that the gross costs of covering the newly eligible aged, blind and disabled would be about $1.8 billion. This figure takes into account the reduction in Medicaid expenditures due to the coverage of the disabled under Medicare and premium payments, as described in the following section.

Employment participants and the "Notch Problem"

Prior Committee Action

The major effect of the Committee's overhaul of the AFDC program has been that all women with children over 6 would be ineligible for welfare and eligible instead for a new employment program. It is estimated that this will result in moving approximately 40 percent of current AFDC recipients from welfare and into the new employment program.

Problem

This Committee action raises a number of issues with respect to the Medicaid program:

1. If those families who move from welfare to the new employment program lose eligibility for Medicaid, it would result in their being substantially worse off under the employment program than they were on welfare. This is contrary to the Committee's previously stated intent that in all cases persons in the employment program would be better off than those on welfare.
2. Additionally, the Committee, in previous actions, has expressed an intent that all participants in the employment program be treated equally. In other words, the Committee did not want an employment participant who has never been on welfare to be worse off than a co-worker who had been on welfare.
3. A "notch problem" arises if Medicaid benefits are suddenly removed at some point in the earnings scale. If a person suddenly will lose Medicaid benefits at a certain income level, there exists a disincentive for him to earn that amount of income.

Proposal

The staff suggests solving the above problems by making participants in the category 1 employment program eligible for Medicaid benefits, subject to payment of an income-related premium. All welfare recipients with total income above specified levels would also be subject to the premium. Thus, people would not be worse off in employment (through loss of medicaid coverage) than they were on welfare.

Those families eligible for a wage subsidy (category 2) or work bonus (category 3) would have the option of securing benefits comparable to Medicaid, but provided outside of the welfare system, by payment of income-related premiums to the Bureau of Health Insurance of the Social Security Administration. Consequently, all employment program participants would be treated equally with their co-workers and a notch problem would not occur because of the premium which would gradually rise with earnings but not in an amount which discouraged earnings.

Under this recommendation, all employment participants could pay premiums toward Medicaid coverage or a special insurance policy providing the mandatory services described in Part A of this booklet.

All welfare recipients and employment participants would be liable for premium payments above the first $200 of monthly income for a family, and above $130 monthly for an individual. The premium would be 10 percent of monthly income between $200 and $300, in the case of a family (or on a yearly basis, 10 percent of income between $2,400 and $3,600) and 20 percent of all income above $300 a month (or on a yearly basis, 20 percent of all income above $3,600). Premium payments would be made on a monthly basis and could in most cases be deducted from assistance payments, employment corporation wages, or work supplement or bonus payments.

Category 1 Employment Corporation families would automatically be covered under Medicaid. Category 2 and 3 families would choose whether to pay premiums towards coverage under a policy providing benefits comparable to Medicaid but issued by the Medicare mechanism, and could voluntarily terminate the special governmental insurance policy (and premium liability) because of coverage through employment or purchase of private health insurance. In view of the large premium, it is expected that the majority of column 3 families would not opt for coverage, as private insurance would probably be as attractive or more attractive.

With premium payments set at 10 percent of monthly income between $200 and $300 and 20 percent of income above this amount, premium payments would amount to $400 at an income of $5,000 per year, at which point the family, if it did not already have group insurance coverage through employment, would probably opt out of the governmental program in favor of private health insurance.

All income from whatever source and without "disregards", would be counted for purposes of determining premium liability.

Cost

The current Medicaid costs (State and Federal) of covering the 1.4 million AFDC families who would move to the employment program and the 250,000 AFDC-related type medically-indigent families who would transfer to the employment program amount to $825 million. This is about equivalent to the estimated Federal cost of covering the people who would be employees of the Employment Corporation, as well as those persons receiving a Federal wage subsidy (categories 1 and 2) assuming premium payments as described above. (see Chart 1)

If all persons receiving the 10 percent work bonus (category 3) were to elect to purchase Medicaid-type insurance from Social Security the total net cost would be $630 million. Although there are 4.5 million people eligible for the 10 percent work bonus, the Federal share of the cost of offering them the option to purchase Medicaid-type insurance would comprise less than 30 percent of the total costs, since the premiums that these families would have to pay would cover the bulk of the cost of the insurance. As previously indicated it is likely that many of these people would opt to purchase regular insurance coverage or receive group insurance through their employers, thus reducing the $630 million cost estimate.

TABLE 1

	Category 1—Employment program	Category 2—Wage subsidy	Category 3—Work bonus
Number of families	1,400,000	500,000	4,500,000
Average wage	[1] $1.50	[2] $2.10	[2] $2.40
Annual wages	$2,400	$4,200	$4,800
Average premium	0	$240	$360
Total cost	$700,000,000	$250,000,000	$2,250,000,000
Total premium	0	$120,000,000	$1,620,000,000
Federal cost of benefits	$700,000,000	$130,000,000	$630,000,000

[1] Per 32 hrs.
[2] Per 40 hrs.

State Responsibility for Premium Payments in States Which Supplement Income Above $2,400

Prior Committee Action

Prior Committee action on the welfare and employment provisions of the bill allowed for State supplementation of basic welfare payments, and mandated that States which supplement welfare payments must supplement employment payments at a higher rate as a means of assuring that, if the State desires to supplement, work will always be more rewarding than non-work under the Committee bill than they are under the present welfare system.

Problem

If the Committee decides, in accordance with the preceding recommendation, to make employment participants' and welfare recipients' participation in Medicaid contingent upon the payment of substantial premiums, a situation could result where many current Medicaid recipients would be worse off than they are under current law, as they would have to pay substantial premiums for services they now receive without charge.

Proposal

If the Committee decides to impose an income-related premium for Medicaid coverage, it would seem appropriate to devise a mechanism, similar to State supplementation on the cash side, which would assure that persons now receiving full Medicaid benefits without having to pay substantial premiums do not end up worse off under the Committee bill.

This could be readily achieved by requiring States which supplement cash payments to be liable for Medicaid premium payments up to the State supplementation level. For example, if a State supplemented the $2,400 for a family of four to $3,600, the State would similarly supplement Medicaid coverage by paying the premium on the income up to $3,600. The recipient would be liable for premium payments above that point. (In the latter case, the State would pay a Medicaid premium of $120—10 percent of the $1,200 supplement above the basic $2,400). State-paid Medicaid premiums, as required above, would be subject to regular Federal matching.

Summary of Costs of Medicaid Proposals

Part A of this booklet contains a series of proposals for modifying the present Medicaid program—the most important of which involves full Federal funding for providing the mandatory Medicaid services to cash assistance recipients. The costs of the Medicaid modifications in Part A totaled $2.8 billion. Of this, $2.4 billion represents revenue sharing. The State-by-State effect of this revenue sharing is detailed in Table I.

The Medicaid modifications in Part A have an additional cost (apart from Federal assumption of $2.4 billion in State and local costs) of about $450 million. Of this $450 million, some $50 million is attributable to Federal funding for Medicaid services in the two States which do not currently have Medicaid programs—Arizona and Alaska.

The other $450 million is the cost of making the Medicaid basic benefit structure equal from State to State and making physician payments parallel to Medicare payments for physicians.

Part B of this booklet contains a number of proposals dealing with the welfare recipients and employment participants who are newly eligible for cash assistance under the Committee bill.

The proposal to cover the newly eligible aged, blind and disabled recipients under medicaid would add a gross cost of about $1.8 billion.

The proposal to cover employment participants under Medicaid with the participants liable for a premium payment would cost about $630 million. It should be noted that this approach not only resolves the "notch" problem but also establishes "break-even" points where families would have financial incentives to select private health insurance coverage as an alternative to the Medicaid-type coverage. The total cost of the programs, therefore, amounts to some $5.2 billion. This $5.2 billion figure assumes that everybody eligible would participate in and utilize the Medicaid program and, therefore, represents the upper limit of estimated cost.

As mentioned above, $2.4 billion of this $5.2 billion increased Federal expenditure represents Federal revenue sharing with the States. The remaining $2.8 billion represents the cost of additional health insurance protection for the poor.

This $2.8 billion can be compared with the Administration's request for increased health insurance coverage for the poor which is estimated to cost $3.2 billion.